

SafetyCounts!

A 'Magnet' for patient safety Hallmark Health System achieves national recognition



In April, Hallmark Health System (HHS) received national recognition of its nursing staff's professionalism, teamwork and patient care excellence by achieving Magnet® recognition. Magnet recognition is determined by the American Nurses Credentialing Center (ANCC), a national organization that works to ensure rigorous standards of nursing excellence.

HHS joins an elite group of hospitals and health care systems: there are only eight Magnet hospitals in Massachusetts and HHS is the only health system in New England to achieve the designation. Nationwide, fewer than 7 percent of hospitals are Magnet organizations.

"It was evident that the Board of Executives has set the vision for this organization around the essential importance of focusing on quality and safety around patient care. It was seen as embraced throughout the organization in being the foundation in the delivery of patient care. We could see while on site the vision around patient safety and quality and safety matters was key throughout all levels of staff."

Excerpt from Magnet Recognition Program® Summary Report

"Magnet recognition is the ultimate benchmark for measuring the quality of patient care," said Judy Thorpe, MS, RN, NE-BC, interim chief nursing officer for HHS. "Achieving Magnet recognition reinforces the culture of excellence that is a cornerstone of how we serve our community. It's also the tangible evidence of our nurses' commitment to providing the very best care to our patients, of which we are extremely proud."

Magnet recognition is now the gold standard for nursing excellence and is a consideration in public examination of health care organizations. For example, *U.S. News & World Report's* annual showcase of "America's Best Hospitals" includes Magnet recognition in its ranking criteria for quality of inpatient care.



Denise Colarusso, unit coordinator, and Robin Watson, RN, discuss a patient care need on West 2 at Lawrence Memorial Hospital.

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CASE STUDY

Pharmacy makes three moves for patient safety

Move #1: In-house compounding

The 2012 tainted-steroids crisis involving the New England Compounding Center (NECC) in Framingham was a wake-up call for hospital pharmacies around the country. More than 750 people were infected with fungal meningitis and more than 60 died. While government agencies cracked down on NECC and other compounding pharmacies, Hallmark Health System (HHS) decided to act.

"Though we didn't use NECC, we felt other outside pharmacies could have similar problems. So we decided to bring compounding in-house and began our own program in 2013," said Michelle Corrado, PharmD, MHA, interim executive director of Clinical Services for HHS. The IV room at HHS now runs 24

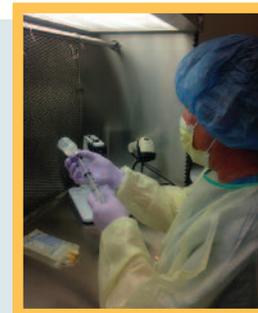
hours a day, mixing IV solutions needed each day.

Move #2: IV bar-coding software

HHS has invested in an IV software program that provides bar coding for the products and improved workflow management for the IV room techs.

Move #3: Pharmacy technician registration program

As a result of the in-house compounding decision, HHS needed to hire additional pharmacy technicians. "The caliber of recruits wasn't there," said Corrado, "so we developed our own training program." Twelve HHS employee/students receive 120 hours each of on-the-job training and classroom work in the nine-month program. The final exam is authorized by the



Registered Pharmacy Technician Bill Dee prepares a sterile IV for a patient.

state's Board of Pharmacy; once students pass the exam and complete the paperwork,

they become registered. HHS is the only hospital in Massachusetts with such a program.

How do these things contribute to patient safety? In-house compounding allows HHS to have more control and oversight of the IV products they produce. The software program ties into other HHS electronic systems already in place and improves the overall safety of medication management for patients. And the pharmacy technician registration program produces graduates who are highly trained and familiar with HHS.

▶ 'Culture of Safety' figures prominently in Magnet recognition

Providing the safest possible patient care within a culture of safety is a top priority for Hallmark Health System (HHS). Nurses are key drivers of the effort to identify patient safety needs and develop, implement and evaluate patient safety initiatives throughout the organization.

The Magnet appraisers and commission received a comprehensive description of 10 patient safety programs in place at HHS. "These examples demonstrate the involvement of nurses from various practice settings and at all levels, and also demonstrate how these initiatives have enhanced the culture of safety and improved patient outcomes," said Diane Hanley, MSN, RN-BC, EJD, associate CNO for Practice, Quality and Education.

- 1. Safe patient handling initiative**, to ensure the safe handling of patients while providing care and the elimination of injuries to nurses in the course of their patient care duties.
- 2. Infant safety**, in particular the upgrading of security systems in clinical buildings and ongoing staff drills and education.
- 3. Patient safety event reporting system (RMPPro)**, an electronic repository for all safety issues that affect patients, visitors and staff.
- 4. Psychiatric consult and 'Code White' support**, an inter-professional plan of care for patients with complex care needs



and behavioral issues, which involves a team approach to maintaining the safety of the patient and others.

- 5. Medication safety**, an effort that uses RMPPro reports to address and learn from medication errors and near misses and uses a regular email communication to educate nurses on safe medication practices, particularly Narcan and pain management.
- 6. Medication reconciliation**, an electronic documentation process in which patients and care providers receive legible, up-to-date medication lists.

- 7. Nursing Grand Rounds**, an ongoing continuing education series focusing on education regarding abuse, neglect and the dynamics of domestic violence.
- 8. Electronic medical record platform**, the conversion to 100 percent electronic documentation, order entry and medication administration documentation; this is a comprehensive source of patient information whose primary goal is enhanced patient safety.
- 9. Bedside report**, a standardized approach to communication about patient care issues during handoffs, primarily at change of shift or transfer from one inpatient area to another; it includes the opportunity for caregivers to ask questions and clarify and confirm information.

- 10. Reducing patient falls**, a longstanding HHS patient safety goal; process changes and capital equipment purchases have resulted in an ongoing decrease in falls across the organization.

Top: Michelle Davolio, RN, Nicole Manning, RN, and Gina D'Ambrosio, RN, confer during their daily huddle on Med 5 at Melrose-Wakefield Hospital.
Bottom: Patient care technician Yolene Armand lends a helping hand to a Melrose-Wakefield Hospital patient.

National Recognition

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One section of the Magnet application process required HHS to demonstrate a culture of safety and included a description of its "Safety Counts" campaign. HHS President and CEO Michael Sack said: "We are trying to create and grow an organizational culture where everyone is engaged in thinking and talking about ways to improve that will have a significant impact on the quality of care and improved patient safety."

The Magnet appraisers and commission reported that it was clear from the "board room to the bedside" that HHS has set a vision and focus on quality and safety.

Get on board!

Join the *SafetyCounts* campaign. Speak up when you see an opportunity to improve the safety of patients, visitors and staff by submitting an RMPPro report or speaking to your manager.



SafetyCounts is published by the HHS Culture of Safety Leadership Committee: Nancy Bittner, PhD, CNS, RN; Thomas Byrne, MD; William Doherty, MD (co-chair); Diane Farragher-Smith, RN; Diane Hanley, MSN, RN-BC, EJD; Lori Howley; Tessa Lucey; Alan Macdonald; Maureen Pierog, RN, (co-chair); Steven Sbardella, MD; Judy Thorpe, RN, MS, NE-C; Johna Wasdyke.

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